

EDITORIAL

Non-gonococcal urethritis may be due to a variety of causes and accurate diagnosis is essential if treatment is to be successful. Detailed history will probably give the clue to whether or not the disease was acquired by sexual contact, and, if it was so acquired, the urethritis is most likely to be of the type commonly called "abacterial" or "non-specific". Nevertheless, it is essential, not only to examine stained smears for specific organisms, but to culture the secretion to determine whether the inflammation is due to pyogenic organisms, and belongs to the group of conditions sometimes known as "bacterial" urethritis. In taking specimens for this examination it is important to cleanse the meatus thoroughly with spirit, for otherwise the normal saprophytic flora may appear to be the cause of the condition. Urethritis, and particularly bacterial urethritis, may result from pathogenic conditions higher in the genito-urinary tract, such as disease of the upper urinary tract or of the bladder, or from urethral stricture which may be due to old gonorrhoea, traumatic urethritis, or infection with *M. tuberculosis*.

If the infection is bacterial, the choice of remedy may be indicated by sensitivity tests carried out on the organism or organisms isolated. If the infection is descending from a lesion of the upper urinary tract, the treatment must be directed against the underlying pathological condition. If strictures are present they should be dilated after the acute inflammation has subsided. Many cases of traumatic urethritis may be cured by dealing with and removing the exciting cause, which may be chemical, mechanical, or thermal.

The treatment of abacterial urethritis of venereal origin has improved considerably since the intro-

duction of antibiotics derived from lower grade fungi, but since the infective agent is still unknown in spite of much investigation in all parts of the world, treatment remains empirical. In the past, urethro-vesical irrigations were the only effective treatment, and this method, which is by no means obsolete, is valuable when antibiotic therapy fails, and is particularly helpful in the treatment of infections due to *Trichomonas vaginalis*. Good results are claimed by combining streptomycin 1 g. intramuscularly, with sulphathiazole 6 g. daily by mouth for 5 days (Lyll, 1953), but the drugs of choice are oxytetracycline, tetracycline, chlortetracycline, and Rovamycin (Spiramycin) (Durel, 1956; Willcox, 1956). The tetracyclines should be given in dosage of 0.5 g. 6-hrly for 4 days, and Rovamycin 4 g. daily for 4 days. With such treatment, if response is incomplete on the fourth day, the course should be continued for 2 more days. Harkness (1954) recommended that, during treatment with these drugs, the intake of fluid should be reduced by half and that urine should be passed frequently, on the assumption that the drugs attack the infecting agent from the urine which thus enhances their effect. Fluids should be taken in large quantities 24 hours after the course of treatment has been completed.

REFERENCES

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